

FORM <b>NHAMCS-100(ED)</b> (9-18-2002)	U.S. DEPARTMENT OF COMMERCE Economics and Statistics Administration <b>U.S. CENSUS BUREAU</b> ACTING AS DATA COLLECTION AGENT FOR THE U.S. Department of Health and Human Services Centers for Disease Control and Prevention National Center for Health Statistics	<b>PATIENT RECORD NO.:</b>	134601
		<b>PATIENT'S NAME:</b>	
<b>NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY 2003 EMERGENCY DEPARTMENT PATIENT RECORD</b>			
<b>Assurance of confidentiality</b> – All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used only by persons engaged in and for the purpose of the survey and will not be disclosed or released to other persons or used for any other purpose without consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).			

<b>1. PATIENT INFORMATION</b>									
<b>a. Date of visit</b> Month    Day    Year			<b>b. ZIP code</b> 		<b>c. Date of birth</b> Month    Day    Year			<b>d. Time of day</b> <input type="checkbox"/> AM <input type="checkbox"/> Military <input type="checkbox"/> PM	
<b>e. Does patient reside in a nursing home or other institution?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown			<b>f. Sex</b> 1 <input type="checkbox"/> Female 2 <input type="checkbox"/> Male		<b>g. Ethnicity</b> 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino			<b>(1) Arrival</b> :    : <input type="checkbox"/> AM <input type="checkbox"/> Military <input type="checkbox"/> PM <b>(2) Time seen by physician</b> :    : <input type="checkbox"/> AM <input type="checkbox"/> Military <input type="checkbox"/> PM <input type="checkbox"/> Not seen by physician <b>(3) Discharge</b> :    : <input type="checkbox"/> AM <input type="checkbox"/> Military <input type="checkbox"/> PM Mark (X) if discharge is more than 24 hours from arrival. <input type="checkbox"/>	
<b>h. Mode of arrival – Mark (X) one.</b> 1 <input type="checkbox"/> Ambulance (air/ground) 2 <input type="checkbox"/> Public service (nonambulance, e.g., police, social services) 3 <input type="checkbox"/> Walk-in 4 <input type="checkbox"/> Unknown			<b>i. Race – Mark (X) one or more.</b> 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black/African American 3 <input type="checkbox"/> Asian 4 <input type="checkbox"/> Native Hawaiian/Other Pacific Islander 5 <input type="checkbox"/> American Indian/Alaska Native			<b>j. Primary expected source of payment for this visit – Mark (X) one.</b> 1 <input type="checkbox"/> Private insurance 2 <input type="checkbox"/> Medicare 3 <input type="checkbox"/> Medicaid/SCHIP 4 <input type="checkbox"/> Worker's Compensation 5 <input type="checkbox"/> Self-pay 6 <input type="checkbox"/> No charge/Charity 7 <input type="checkbox"/> Other 8 <input type="checkbox"/> Unknown			
<b>2. TRIAGE</b>									
<b>a. Initial vital signs</b>		<b>(1) Temperature</b>		<b>(3) Blood pressure</b> /		<b>b. Immediacy with which patient should be seen</b> 1 <input type="checkbox"/> Unknown/No triage 2 <input type="checkbox"/> Less than 15 minutes 3 <input type="checkbox"/> 15–60 minutes 4 <input type="checkbox"/> >1 hour–2 hours 5 <input type="checkbox"/> >2 hours–24 hours		<b>c. Presenting level of pain</b> 1 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> None 3 <input type="checkbox"/> Mild 4 <input type="checkbox"/> Moderate 5 <input type="checkbox"/> Severe	
<b>3. REASON FOR VISIT</b>									
<b>a. Patient's complaint(s), symptom(s), or other reason(s) for this visit</b> Use patient's own words. (1) _____ (2) _____ (3) _____					<b>b. Is this visit related to alcohol use?</b> 1 <input type="checkbox"/> Yes, patient's use 2 <input type="checkbox"/> Yes, other person's use 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Unknown		<b>c. Is this visit work related?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown		<b>a. Has patient been seen in this ED within the last 72 hours?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown
<b>4. CONTINUITY OF CARE</b>									
<b>b. Episode of care</b> 1 <input type="checkbox"/> Initial visit for problem 2 <input type="checkbox"/> Follow-up visit for problem 3 <input type="checkbox"/> Unknown									
<b>5. INJURY/POISONING/ADVERSE EFFECT</b>									
<b>a. Is this visit related to an injury, or poisoning, or adverse effect of medical treatment?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – SKIP to item 5.		<b>b. Is this injury/poisoning intentional?</b> 1 <input type="checkbox"/> Yes, self inflicted 2 <input type="checkbox"/> Yes, assault 3 <input type="checkbox"/> No, unintentional 4 <input type="checkbox"/> Unknown		<b>c. Cause of injury, poisoning, or adverse effect – Describe the place and events that preceded the injury, poisoning, or adverse event (e.g., allergy to penicillin, bee sting, pedestrian hit by car driven by drunk driver, wife beaten with fists by husband, heroin overdose, infected shunt, etc.).</b> _____ _____ _____					
<b>6. PHYSICIAN'S DIAGNOSIS FOR THIS VISIT</b>									
<b>As specifically as possible, list diagnoses related to this visit including chronic conditions.</b>		<b>(1) Primary diagnosis:</b> _____ <b>(2) Other:</b> _____ <b>(3) Other:</b> _____							
<b>7. DIAGNOSTIC/SCREENING SERVICES</b>					<b>8. PROCEDURES</b>			<b>9. MEDICATIONS &amp; INJECTIONS</b>	
<b>Mark (X) all ordered or provided at this visit.</b> 1 <input type="checkbox"/> NONE <b>Examinations/Tests:</b> 2 <input type="checkbox"/> Medical screening exam 3 <input type="checkbox"/> Mental status exam 4 <input type="checkbox"/> EKG/ECG (electrocardiogram) 5 <input type="checkbox"/> Cardiac monitor 6 <input type="checkbox"/> EEG (electroencephalogram) 7 <input type="checkbox"/> Pulse oximetry 8 <input type="checkbox"/> Pregnancy test 9 <input type="checkbox"/> Urinalysis (UA) <b>Imaging:</b> 10 <input type="checkbox"/> Chest X-ray 11 <input type="checkbox"/> Extremity X-ray 12 <input type="checkbox"/> Other X-ray 13 <input type="checkbox"/> Ultrasound 14 <input type="checkbox"/> MRI/CAT scan 15 <input type="checkbox"/> Other imaging <b>Blood tests:</b> 16 <input type="checkbox"/> CBC (complete blood count) 17 <input type="checkbox"/> BUN (blood urea nitrogen) 18 <input type="checkbox"/> Creatinine 19 <input type="checkbox"/> Lipids/Cholesterol 20 <input type="checkbox"/> Glucose 21 <input type="checkbox"/> HgbA1C (glycohemoglobin) 22 <input type="checkbox"/> Electrolytes 23 <input type="checkbox"/> BAC (blood alcohol) 24 <input type="checkbox"/> HIV serology 25 <input type="checkbox"/> Other blood test <b>Cultures:</b> 26 <input type="checkbox"/> Blood 27 <input type="checkbox"/> Cervical/Urethral 28 <input type="checkbox"/> Stool 29 <input type="checkbox"/> Throat/Rapid strep test 30 <input type="checkbox"/> Urine 31 <input type="checkbox"/> Other test/service					<b>Mark (X) all provided at this visit. Exclude medications.</b> 1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> Bladder catheter 3 <input type="checkbox"/> CPR 4 <input type="checkbox"/> Endotracheal intubation 5 <input type="checkbox"/> Eye/ENT care 6 <input type="checkbox"/> IV fluids 7 <input type="checkbox"/> NG tube/gastric lavage 8 <input type="checkbox"/> OB/GYN care 9 <input type="checkbox"/> Orthopedic care 10 <input type="checkbox"/> Thrombolytic therapy 11 <input type="checkbox"/> Wound care 12 <input type="checkbox"/> Other			<b>a. What is the total number of drugs prescribed or provided at this visit?</b> _____ Include Rx and OTC medications, immunizations, allergy shots, anesthetics, and dietary supplements that were ordered, supplied, administered or continued during this visit. <b>b. List up to 8 medication/injection names below.</b> (1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____ (7) _____ (8) _____	
<b>10. VISIT DISPOSITION</b>					<b>11. PROVIDERS SEEN</b>				
<b>Mark (X) all that apply.</b> 1 <input type="checkbox"/> No follow-up planned 2 <input type="checkbox"/> Return if needed, PRN/appointment 3 <input type="checkbox"/> Return to referring physician 4 <input type="checkbox"/> Refer to other physician/clinic for FU 5 <input type="checkbox"/> Refer out from triage without treatment 6 <input type="checkbox"/> Refer to alcohol or drug treatment program 7 <input type="checkbox"/> Return to non-physician treatment or support service 8 <input type="checkbox"/> Left before being seen 9 <input type="checkbox"/> Left AMA 10 <input type="checkbox"/> Admit to ED for observation 11 <input type="checkbox"/> Admit to hospital 12 <input type="checkbox"/> Admit to ICU/CCU 13 <input type="checkbox"/> Transfer to other facility 14 <input type="checkbox"/> DOA/died in ED 15 <input type="checkbox"/> Other					<b>Mark (X) all that apply.</b> 1 <input type="checkbox"/> Staff physician 2 <input type="checkbox"/> Resident/Intern 3 <input type="checkbox"/> Other physician 4 <input type="checkbox"/> RN 5 <input type="checkbox"/> LPN 6 <input type="checkbox"/> Nurse practitioner 7 <input type="checkbox"/> Physician assistant 8 <input type="checkbox"/> EMT 9 <input type="checkbox"/> Other technician 10 <input type="checkbox"/> Other				
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